F DOUGLASS COUNTY, NEBRASKA

RYAN H. STREIT and COURTNEY STREIT, husband and wife,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD Of NEBRASKA,

Defendant.

Case # CI 15- 3381

AMENDED COMPLAINT

I.

Defendant is an insurance company, real name and nature unknown, with its principal place of business in Douglas County, Nebraska.

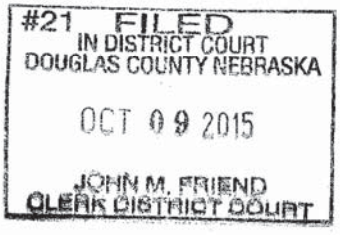
II.

On approximately May 1, 2007, the plaintiffs entered into a health insurance contract with the defendant, policy number YEB7745859TF, providing coverage for their family, including their daughter, Kayli Streit. Effective February 1, 2010, the policy number was changed to YED887085199, but the terms of the policy did not change. Copies of the contract booklet and schedules of benefits for 2007, 2008 and 2009 are marked exhibits 1 through 4 and attached.

III.

The plaintiffs complied in all respects with the contract and timely paid all premiums. They made no request to exclude Kayli from coverage. Nonetheless, by letter of April 14, 2010, Kayli was excluded from policy YEB7745859TF on account of a kidney condition. Likewise, on May 31 2010, Kayli was dropped from policy number YED887085199.

EXHIBIT A



IV.

The termination of coverage for Kayli was not authorized under the contract or requested by the plaintiffs. The defendant's unilateral exclusion of Kayli from coverage constitutes breach of the contract.

V.

As a direct result of the defendant's breach, the plaintiffs have paid, or are paying, medical bills in an amount not yet determined that should have been covered under the contract.

WHEREFORE, Plaintiffs pray for judgment against the defendant, in the amount of their special damages as proven at trial, general damages as provided by law and the taxable costs of this action.

Plaintiffs, by:

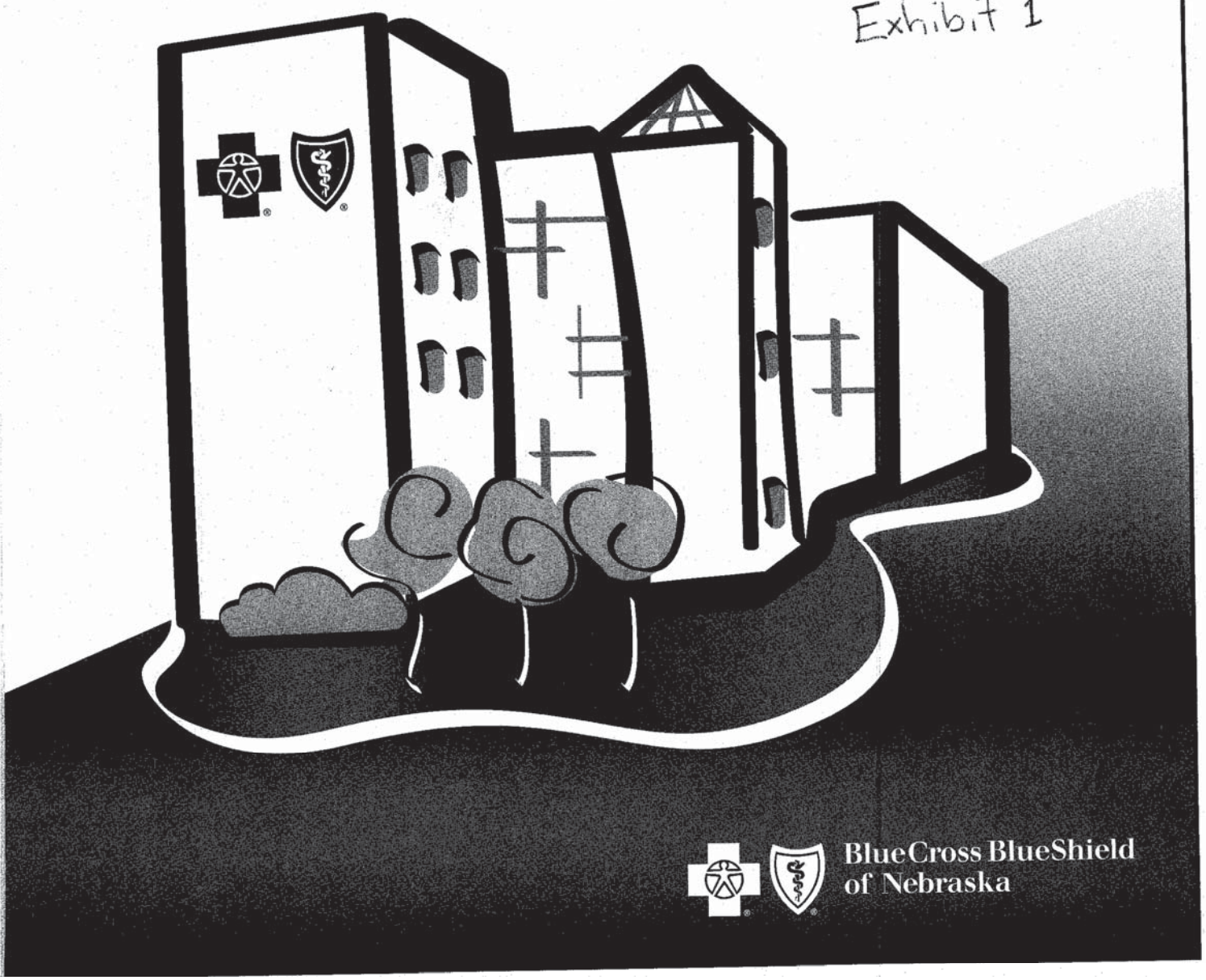
MARTIN A. CANNON, #18769
Cannon Law Offices
24000 210th Street
Crescent, Iowa 51526
(402) 455-6000 / 4033 fax

A Guide to Your BluePreferred Health Benefits

BluePride for Small Employers

98-339 4/2007

Exhibit 1



Blue Cross Blue Shield of Nebraska

About Your Certificate Of Coverage

This document is your Certificate of Coverage. It has been written to help you understand your group health coverage with Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross and Blue Shield Association.

This Certificate of Coverage is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract. The certificate describes the more important parts of the contract but is not to be considered the Contract. Your coverage is governed by the terms of the Master Group Contract.

The Master Group Contract is issued in and governed by the laws of the State of Nebraska. Please note that this Certificate of Coverage may not list all the benefits provided by the laws of your state if you do not reside in Nebraska.

It is important that you read this Certificate of Coverage carefully and share the information with your eligible dependents. Additional copies of this document or your Schedule of Benefits, are available from Blue Cross and Blue Shield of Nebraska's Customer Service Center. If you have a question about your coverage or claim, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Important Telephone Numbers

customer service:

Omaha 402-390-1820
Toll-free 1-800-642-8980
TTY/TTD (for the hearing impaired) 402-390-1888

coordination of benefits:

Omaha 402-390-1840
Toll-free 1-800-462-2924

subrogation:

Omaha 402-390-1847
Toll-free 1-800-662-3554

workers' compensation:

Omaha 402-398-3615
Toll-free 1-800-821-4786

preadmission/admission certification:

Omaha 402-390-1870
Toll-free 1-800-247-1103

BlueCard provider information:

Toll-free 1-800-810-BLUE (2583)
Web site . . . . . .www.bcbs.com

pharmacy locator:

Toll-free 1-877-800-0746

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Summary of Benefit Maximums

Total Benefits Per Covered Person:	
SERVICE	**BENEFIT MAXIMUM**
Overall Maximum	*$10,000,000*
Substance Abuse (Please refer to your Schedule of Benefits to verify if your health plan option provides coverage for substance abuse.)	*$10,000*
Home Health Aide, Skilled Nursing Care and Hospice Services	
Skilled Nursing Facility	*60 Days Per Calendar Year*
Skilled Nursing Care Services	*60 Days Per Calendar Year*
Inpatient Hospice	*30 Days Per Calendar Year*
Respite Care	*20 Day Maximum*
Medical Social Services	*8 Session Maximum*
Bereavement Counseling	*5 Session Per Family Member*
Hospice Services (all inclusive inpatient and outpatient)	*60 Days Per Calendar Year*
Respiratory Care	*60 Days Per Calendar Year*
Other Covered Services	
Diabetes Education	*$500 Per Calendar Year*
Home Medical Equipment (HME)	*$5,000 Per Calendar Year*

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Some Important Facts About Your Coverage

This Group Health Plan is a preferred provider organization (PPO) health benefit plan, insured by Blue Cross and Blue Shield of Nebraska.

BluePreferred is a Preferred Provider Organization (PPO) established by Blue Cross and Blue Shield of Nebraska through contracts with a panel of hospitals, physicians and other health care providers who have agreed to furnish medical services to you and your family in a manner that will help manage health care costs. These providers are referred to as "Blue*Preferred*" or "Preferred Providers."

Blue Cross and Blue Shield Plans in other states (on-site plans) have also contracted with health care providers in their geographic areas who are referred to as "Preferred Providers."

By using Preferred Providers, you benefit from these important advantages:

- Lower deductible requirements in most cases.
- Lower coinsurance requirements in most cases.
- Preferred Providers accept your copayment, deductible and/or coinsurance plus this group plan's benefit payment as payment in full for a covered service. When a Preferred Provider is used, you are not responsible for charges in excess of the contracted amount for a service.
- Benefits for your services are paid directly to contracting providers.

You do not have to pay a Preferred Provider more than a copayment, deductible and/or coinsurance amount at the time covered services are provided. **Preferred Providers will also file claims for you.**

Blue Cross and Blue Shield Plans across the country participate in a national program called the BlueCard Program. Each plan has a networ of providers who specifically have agreed to participate as BlueCard Program network (PPO) providers. These providers will also be referred to as "Preferred Providers." The BlueCard Program enables the Blue Cross and Blue Shiel Plan servicing the geographic area where treatment is provided to process the claim, and allows you to take advantage of the local plan's contracting provider agreements.

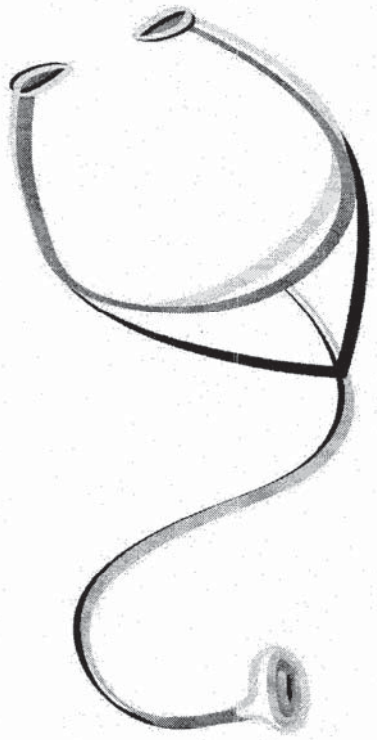
USING YOUR BENEFITS WISELY

Blue Cross and Blue Shield of Nebraska wants you to get the most from your group health coverage. You can save yourself a considerable amount of time and money by making efficient use of the health care system.

As you read this document, some "Good Care Tips for efficient health care will be highlighted in boxes just like this one.

Selecting A Provider

No matter where you are when you require health care services, whether you are in Nebraska or in another state, selection of a provider of care always remains your choice. However, the provider you choose may make a difference in the amount of benefits your coverage provides and, therefore, whether your liability will be more or less.



In the Blue*Preferred* Service Area (Nebraska)

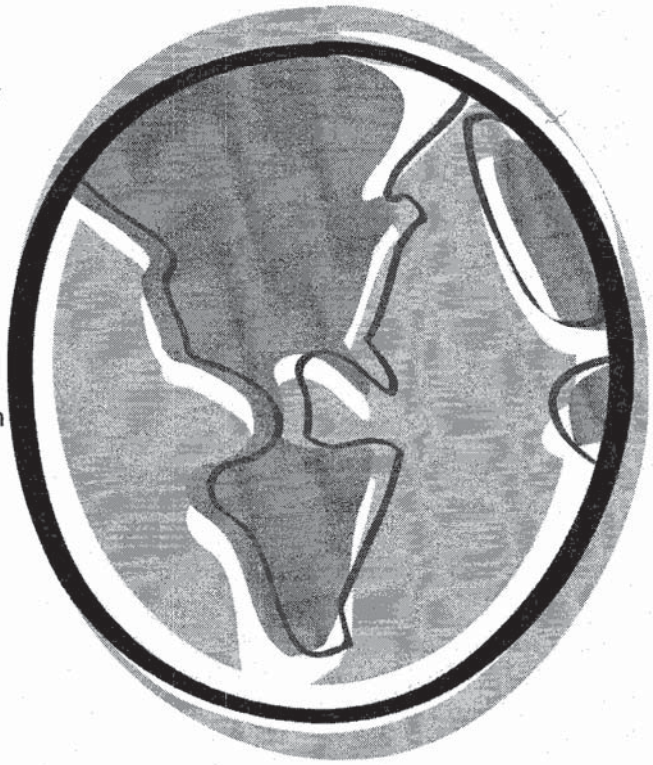
Selection of a provider of care always remains your choice. If you choose a Blue*Preferred* Provider, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Blue*Preferred* Provider, contact Blue Cross and Blue Shield of Nebraska's Customer Service Center at their toll-free number (1-800-642-8980). A directory of *BluePreferred* Providers is available upon request or at the Blue Cross and Blue Shield of Nebraska website: **www.bcbsne.com**.

Outside the Blue*Preferred* Service Area

Selection of a provider of care still remains your choice. If you receive care from a provider who is a Preferred Provider with the on-site Blue Cross and/or Blue Shield Plan, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield service area, you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

Also, for help in locating a provider, you can visit the "BlueCard PPO Provider Finder" at the Blue Cross and Blue Shield Association website: **www.bcbs.com.**

BlueCard Program



Blue Cross and Blue Shield plans across the country participate in the BlueCard Program. This program enables the Blue Cross and Blue Shield plan servicing the geographic area where health care services are provided (on-site plan) to receive and process claims for covered services.

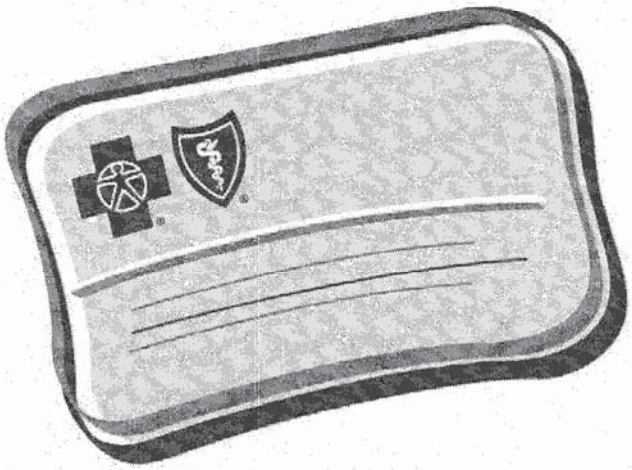
When you obtain health care services through the BlueCard Program outside the geographic area Blue Cross and Blue Shield of Nebraska serves, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The contracted amount that the on-site Blue Cross and Blue Shield Plan (Host Blue) passes on to Blue Cross and Blue Shield of Nebraska.

Often, this contracted amount will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements with your health care provider or with a specified group of providers. The contracted amount may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The contracted amount may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered the final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate subscriber liability calculation methods that differ from the usual BlueCard method noted above, or require a surcharge, Blue Cross and Blue Shield of Nebraska would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Your I.D. Card — A Passport to Health Care



Blue Cross and Blue Shield of Nebraska will issue you an identification card. Your I.D. number is a unique alpha numeric combination including an alpha prefix and a numeric suffix. If other members of your family are covered by your membership, their names and dates of birth will also appear on your I.D. card. Each family member will be assigned a different numeric suffix. Only five names can appear on one I.D. card; therefore, you will receive more than one card if there are more than five eligible family members.

Always put your I.D. card in your wallet or purse, along with your driver's license, credit cards and other essential items. With your Blue Cross and Blue Shield of Nebraska I.D. card, U.S. hospitals and physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center. Remember, only persons who are eligible for coverage under your membership may use your Blue Cross and Blue Shield of Nebraska I.D. card.

Schedule of Benefits

Your Schedule of Benefits is a personalized document that provides information concerning: Preferred and non-Preferred Provider deductibles, coinsurance, copayment amounts, special benefits, and maximums and limitations of your coverage. It also identifies the type of membership option you have and indicates if any waiting periods are in effect.

Please refer to your Schedule of Benefits for additional information which may be unique to your coverage.

Eligibility & Enrollment

Eligibility for Coverage

Subscriber and dependent eligibility is subject to the requirements set forth in the Master Group Contract between Blue Cross and Blue Shield of Nebraska and your employer. Subscribers and dependents must enroll within 31 days of their initial eligibility, or late enrollment provisions may apply. Coverage will be effective on the date the next monthly premium is due following the initial eligibility date. If you acquire dependents through marriage, birth or adoption, a 31-day special enrollment period is allowed to request coverage for them under this group health plan.

Please see the sections titled "Special Enrollment" and "Late Enrollment" for additional information. You may also contact Blue Cross and Blue Shield of Nebraska's Customer Service Center for information.

Your group health plan may include a waiting period for pre-existing conditions for all eligible subscribers and their dependents. Please check with your personnel office for specific information. You may also contract Blue Cross and Blue Shield of Nebraska's Customer Service Center for information.

Types of Membership

There are four types of enrollment options offered by Blue Cross and Blue Shield of Nebraska. The enrollment option you have elected is shown on your Schedule of Benefits.

Single Membership: Provides coverage for you only.

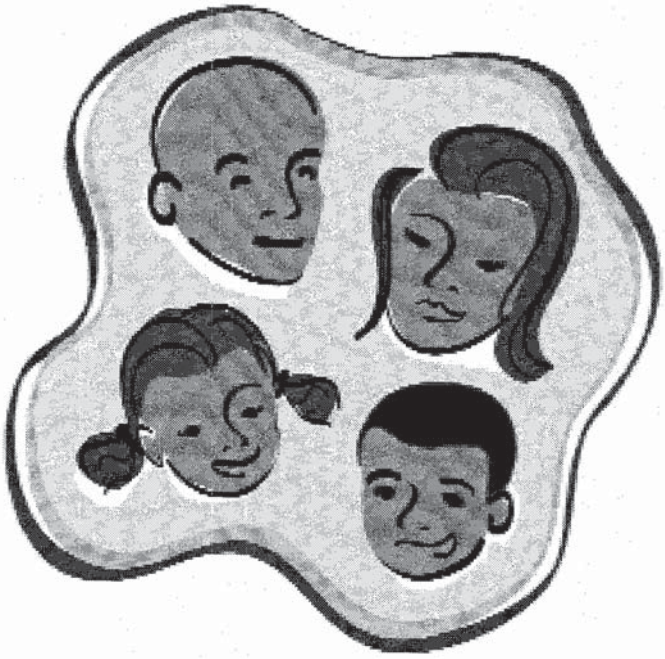
Subscriber-Spouse Membership: Provides coverage for you and your spouse.

Subscriber-Child(ren) Membership: Provides coverage for you and your eligible dependent children, but not for your spouse.

Family Membership: Provides coverage for you, your spouse and your eligible dependent children.

Eligible Dependent is defined in the Definitions section of this book.

Note: *If two eligible persons in the same employer group are married to each other, each person and/or their eligible dependents may not enroll under more than one membership option.*



Special Enrollment

A special enrollment period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons not previously covered under this plan due to having had other coverage at the time it was previously offered, and who have lost that other coverage due to:

  exhaustion of COBRA continuation coverage, or

  a loss of eligibility, including loss due to death, divorce, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person, or

  moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area, or

  the lifetime limit on all benefits is exhausted, or

  the employer ceasing to make contribution for the other coverage.

The subscriber must enroll (or already be enrolled) in order to enroll his or her dependents in this plan. In the case of a marriage, birth or adoption, a subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly eligible dependent. Likewise an eligible spouse who has not previously enrolled, may enroll as a special enrollee with or without a new dependent child. A special enrollee, other than a newborn, adopted child or a child placed for adoption, will be subject to the 12-month waiting period for pre-existing conditions with credit given for prior creditable coverage. Please contact your Human Resource Department for additional information.

Late Enrollment

A "late enrollee" is defined as a subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. An eligible person who enrolls for coverage during a "special enrollment period" is not considered a late enrollee. A late enrollee will be subject to an **18-month waiting period** for pre-existing conditions.

Please note that in order to avoid late enrollment restrictions, you must request enrollment within 31 days of your (or your dependent's) initial eligibility, or during a special enrollment period, if applicable.

Your group health plan may have additional restrictions regarding late enrollment. Please check with your Human Resources Department, or contact Blue Cross and Blue Shield of Nebraska for information.

Waiting Period for Pre-existing Conditions

Your Schedule of Benefits shows whether or not a waiting period for pre-existing conditions applies to your (or your dependent's) coverage. If a waiting period applies, no benefits will be paid for a pre-existing condition for a period of 12 months (18 months for a late enrollee) from the earlier of the effective date of coverage or the first day of the eligibility waiting period (if any).

The waiting period for pre-existing conditions does not apply to a child who is born, adopted or placed for adoption after your effective date of coverage, who is otherwise eligible for coverage, and enrolled within 31 days of the birth, adoption or placement for adoption. Nor does it apply to such a child who, as of the last day of a 31-day period beginning on the date of birth, adoption or placement for adoption was covered under other creditable coverage which ended not more than 63 days prior to the enrollment in this plan.

A **pre-existing condition** is defined as a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the first day of coverage, or if there is an eligibility waiting period, the first day of such waiting period. A pre-existing condition does not include a pregnancy. Genetic information shall not be treated as a pre-existing condition unless there is a diagnosis of the condition related to such information.

Reduction of waiting period - The waiting period for pre-existing conditions may be reduced or waived by periods of prior creditable coverage if there is not a significant break in coverage. A significant break in coverage is a period of 63 days during which the individual does not have any creditable coverage. Days of creditable coverage that occur before a significant break in coverage will not be counted toward the reduction of a waiting period. Neither an Eligibility Waiting Period nor an HMO affiliation period is taken into account in determining a significant break in coverage.

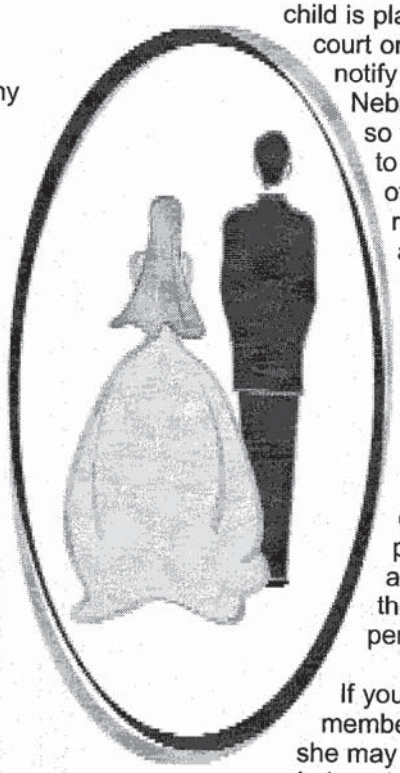
The individual is responsible for providing satisfactory evidence of creditable coverage in order to reduce the waiting period. The method of calculating creditable coverage will be based on the applicable provisions of the Health Insurance Portability and Accountability Act of 1996. You may request a "certificate of creditable coverage" from your prior plan(s) or health insurer(s). If necessary, we will help you obtain it from them. Please contact your plan administrator for assistance, or you may contact the Blue Cross and Blue Shield of Nebraska Customer Service Center.

"Creditable Coverage" is defined in the "Definitions" section of this document.

Marriage

When you marry, your spouse and any other new eligible dependents may enroll for coverage under an appropriate membership unit offered by your group plan. A 31-day period is allowed to make a change to your membership if necessary, and to request coverage for the new dependents. If the request is received within 31 days of the marriage, the effective date of coverage will be no later than the first day of the first month following the receipt of the enrollment form.

If the request for coverage is not made within 31 days of the marriage, late enrollment provisions may apply. Please see the section titled "Late Enrollment" for additional information.



Newborn Children

Coverage shall begin at birth for your newborn child. If you already have a Family or Subscriber-Child(ren) Membership in effect on the date of birth, please notify Blue Cross and Blue Shield of Nebraska of the birth within 31 days, so that they may update your records. If any additional premium is required to provide coverage for the newborn, payment must occur within 31 days of the birth in order to continue coverage beyond the initial 31-day period.

If you have a Single or Subscriber-Spouse Membership in effect at the time of birth, coverage will be provided for the child for 31 days. To continue coverage for the newborn, you must request a change to Subscriber-Child(ren) or Family Membership within this 31-day period, and pay the additional premium.

If your spouse was not enrolled under your membership at the time of the child's birth, he or she may also enroll for coverage during this 31-day period, and the effective date of coverage for your spouse will be the date of the child's birth. The applicable premium for Family Membership must be paid for the entire month.

If you request enrollment of the child (and spouse, if applicable) after the 31-day period, late enrollment provisions may apply.

Adopted Children

If you are adopting a child, the effective date of the child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you. Please notify Blue Cross and Blue Shield of Nebraska within 31 days of the placement, so that they may update your records and to avoid any future delay in the payment of claims. If any additional payment is required to provide coverage for the adopted child, payment must occur within 31 days of the adoption in order to continue coverage beyond the initial 31-day period.

If you have a Single or Subscriber-Spouse Membership in effect, you must request a change to Subscriber-Child(ren) or Family Membership and enroll the child within 31 days of the placement for adoption and pay the additional premium, in order to continue the coverage beyond the initial 31-day period.

If your spouse was not enrolled under your membership at the time of the adoption, he or she may enroll for coverage during this 31-day period, and the effective date of coverage for your spouse will be the date the child is placed with you for adoption. The applicable premium must be paid.

If you request enrollment of the child (and spouse, if applicable) after the 31-day period, late enrollment provisions may apply.

Disabled Dependent Children

A physically or mentally disabled child may remain an eligible dependent child upon reaching age 19 if incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and dependent upon you for support and maintenance. The application for such coverage must be received within 31 days of the dependent's 19th birthday and the dependent must meet all other group coverage eligibility requirements.

A child who becomes physically or mentally disabled while a covered student over 18 years of age may continue under your health care coverage while remaining incapable of returning to school as a full-time student, unmarried and dependent upon you for support and maintenance. You must furnish proof of disability within 31 days of its onset. (This extended coverage is subject to all other group coverage requirements.)

An application for extension of dependent coverage is available through Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity disputes. The order may direct the group health plan to enroll the child(ren), and also creates a right for the alternate recipient to submit claims and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Ages 65 and Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may elect to continue full benefits under the employer group benefit plan or choose Medicare as their primary coverage. If the group plan is elected as the primary carrier (the plan which pays first), Medicare becomes the secondary coverage. If Medicare is elected as the primary carrier, coverage under the group plan will be terminated. This law applies to employers with 20 or more employees. **Please check with your employer regarding whether your group is subject to this federal law.**

Family Medical Leave Act (FMLA)

Public Law 103-3 (FMLA) requires that, subject to certain limitations, an employer of 50 or more persons offer continued coverage to employees and their eligible dependents, while the employee is on FMLA leave for birth, adoption or foster care placement of a child, or due to a serious health condition of the employee or his/her son, daughter, spouse or parent. In addition, an employee who has terminated his/her group health coverage while on approved FMLA leave may reenroll for group health coverage upon return to employment. **Please check with your employer for details regarding your eligibility under FMLA.**

Termination Of Coverage

Coverage under your health plan will terminate on the earliest of the following dates:

- The date the entire Contract is terminated.
- The last day of the month in which you terminate employment.
- The last day of the month in which you cease to be eligible under the health plan, or a dependent ceases to be an eligible dependent.
- The last day of the month in which we receive a request from you or the employer to terminate coverage for you or a dependent, or the first date the premium is due after our receipt of your written request to cancel, if later.
- The last date for which premium was paid.

You and/or your eligible dependents may be eligible to continue coverage under the health plan, or purchase a nongroup conversion policy, as detailed in the following sections.

Continuation Of Coverage

If you terminate your employment, or if a dependent loses coverage due to certain "qualifying events," continued coverage under the group health plan may be available. Payment for continuation coverage is at the employee's or dependent's own expense.

Your continuation of coverage option depends upon whether your employer is subject to state or federal continuation laws, based on the size of the the employer. Federal continuation law (COBRA) is applicable to most employers with 20 or more employees. State continuation law is applicable to Nebraska employers with 19 or less employees.

The continuation of coverage options are described in the following sections. Please contact your employer to determine if state or federal law applies, and for details regarding eligibility.

State Continuation Law

Nebraska state law applies to employers with 19 or less employees. The law provides that if you are involuntarily terminated from your employment for reasons other than misconduct, you may continue your group health coverage for a period of up to six months.

This law also provides that if you should die while you are employed and covered under this group health plan, your surviving spouse and children may continue the group coverage for up to one year.

Your employer will provide you, or your survivors, with instructions as to how to apply for this coverage within 10 days of the termination or death, if eligible. The election form and the first month's premium must be returned within the time period indicated in the notice and instructions.

If elected, the coverage will continue for the time period indicated (6 months or one year) provided that timely premium payments are made, but may be terminated sooner if:

- The group health plan is terminated, or your employer discontinues participation in the plan;
- You, or your covered survivors become eligible for other group health coverage; or
- The covered person converts to a conversion policy, if available.

Federal Continuation Law (COBRA)

The Consolidated Omnibus Reconciliation Act (COBRA), is a federal law which provides that covered employees and their dependents may elect to continue coverage under the group health plan if coverage is lost due to the occurrence of certain "qualifying events." These events are described below as well as the procedures for electing COBRA continuation coverage. Persons who are eligible to continue coverage are called "qualified beneficiaries." **Payment for continuation coverage is at the employee's or dependent's own expense.**

Please share the COBRA information found in this section with your eligible dependents.

Termination of Employment or Reduction in Hours
COBRA, provides that if you should lose eligibility for coverage due to:

- a reduction in work hours
- termination of employment
- a layoff, or
- discharge for misconduct (other than gross misconduct),

you and your covered dependents may be able to continue the group coverage at your own expense for **up to 18 months.** Your employer is required to notify the plan administrator within 30 days. The plan administrator will send the qualified beneficiaries a COBRA notification within 14 days after receiving notice from the employer.

Special provisions regarding COBRA eligibility for certain retirees may apply if an employer files a Chapter 11 bankruptcy. Please check with your employer for details.

Disability--If a qualified beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA coverage, the COBRA coverage period may be extended from **18 to 29 months.** You must provide written notice of the disability determination to the plan within 60 days of the later of the Social Security Administration's determination or the qualifying event, and before the end of the initial 18-month COBRA period.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage (19th through 29th month) will be terminated the month that begins more than 30 days after the final determination.
You must notify the plan within 30 days of a final determination that the individual is no longer disabled.

Change in Dependent Status, Divorce or Separation or Medicare Entitlement -- COBRA requires that continued coverage under your group plan be offered to your covered spouse and eligible dependent children if they would otherwise lose coverage as the result of:

- a child losing dependent status
- divorce or legal separation, or
- you becoming entitled to Medicare.

When one of these circumstances occurs, you are obligated to notify your employer or plan administrator within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.

After receiving a timely notice of such an event, your employer or plan administrator will send your spouse or dependents an election form and information needed to apply for coverage, if eligible. The coverage may be continued at his/her expense **for up to 36 months.**

Your Death -- If you should die while you are covered under this group plan, continued coverage under this group plan is available to your spouse and eligible dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group coverage at their own expense for up to 36 months. Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage, if they are eligible.

Electing COBRA Coverage -- Please share the COBRA information found in this section with your eligible dependents, in the event that a qualifying event occurs.

Within 14 days after notice of a qualifying event is received by the plan administrator, you and/or your dependents will be sent a written notice of the right to continue health coverage, and an election form(s).

Reminder: *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or plan administrator of this qualifying event within 60 days after the later of the event or the date the coverage would be lost.*

Qualified beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions to help you complete the form, and to whom it should be sent.

The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or plan administrator.

COBRA continuation coverage may only begin on the day after coverage under the plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to who such premium should be paid.

Second Qualifying Event--In the event your family experiences another qualifying event while receiving an 18-month period of COBRA coverage (or the extended 29 month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months, if notice of the second event is properly given to the employer or plan administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die, b) you become entitled to Medicare, c) you get divorced or legally separated, or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred. In all of these cases, you or the dependent must notify the employer or plan administrator within 60 days of the second qualifying event.

Termination of COBRA Coverage -- A qualified beneficiary's COBRA continuation coverage will end at midnight on the earliest of:

- the day your employer ceases to provide any group health plan to any employee,
- the day the premium is due and unpaid,
- the day the individual first becomes covered under any other group health plan (after the COBRA election), which does not exclude or limit any pre-existing conditions or to whom such an exclusion is not applicable due to creditable coverage,
- the day an insured person again becomes covered as an employee or dependent under the policy,

- the day an insured person becomes entitled to benefits under Medicare (after the COBRA election), or
- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

Note: *In the event more than one continuation provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*

Trade Adjustment Assistance (TAA) Reform Act of 2002

The Trade Adjustment Assistance (TAA) Reform Act provides benefits to individuals eligible for trade adjustment assistance because international trade has adversely affected their employment. The Act provides that a TAA eligible individual who did not elect continuation coverage during the initial COBRA election period is entitled to a second 60-day election period. This election must take place no later than six months after the date of the TAA related loss of coverage. The Act also includes a federal tax credit of 65% of premiums paid for qualified private health insurance coverage, including COBRA coverage.

Additional information regarding requirements and benefits under the TAA Reform Act may be obtained from the U.S. Department of Labor or the Nebraska Workforce Development, Department of Labor.

Uniformed Services Employment And Reemployment Rights (Military Leave)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer group health plan be offered to an employee and covered dependents if coverage would otherwise be lost due to a military leave.

Continuation of Group Health Coverage:

If coverage under your employer group health plan ends because of service in the uniformed services, you may elect to continue health coverage for yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A covered person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any group health plan for its employees;
- the day premium is due and unpaid;
- the day a covered person again becomes covered under the plan;
- the day coverage has been continued for the period of time stated in the previous paragraph, above.

Reemployment:

Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for group health coverage provided by the employer, with no new waiting periods imposed.

Please contact your Human Resources or Personnel Department for further information regarding your rights under USERRA.

Understanding Your Health Coverage

Your group health coverage consists of a wide variety of benefits:

Inpatient Hospital and Facility Benefits

Outpatient Benefits

Physician Medical-Surgical Benefits

Mental Illness and Substance Abuse Benefits

Oral Surgery and Dentistry Benefits

Organ/Tissue Transplant Benefits

Home Health Aide, Skilled Nursing Care, Hospice and Skilled Nursing Facility Benefits

Other Benefits — Including such services as ambulance service, physical therapy, speech therapy, home medical equipment and certain other services.

Prescription Drug Card Benefits — Benefits are available for covered prescription medications, insulin, injectables (including needles and syringes), and diabetic and ostomy supplies under the Rx Nebraska Prescription Drug program. Please note that Rx Nebraska is not a part of the BluePreferred network.

Remember: *With this plan, it is to your advantage to use the network of BluePreferred or Preferred Providers, but it still remains your choice. If you use a Preferred Provider, you are eligible to receive the highest benefit level (preferred) possible under this plan for covered services. If you use a non-Preferred Provider, you are still eligible to receive benefits for covered services, but the benefit level (non-preferred) for these services will usually be less than if you had gone to a Preferred Provider.*

Exception: *If you receive initial inpatient or outpatient care for an emergency medical condition at a non-Preferred hospital or by a non-Preferred provider, benefits for covered services for the initial care will be provided at the Preferred Provider benefit level.*

Please refer to the section in this booklet "Inpatient Notification, Certification and Concurrent Review" for information regarding certification of emergency admissions.

Reminder: *If more than one physician is involved in your care, it is important for you to check the preferred status of each provider. This is especially important when you are receiving services from multiple providers while hospitalized. If you wish to stay within the Preferred Provider network, make sure your attending physician knows this. Ask that you be informed, before the service is performed, if he or she is referring you to a provider outside the Preferred Provider network.*

Important Health Coverage Terms

Allowable Charge — Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by Preferred or Contracting Providers will be a contracted amount for the service. The allowable charge for services by nonContracting Providers will generally be the lesser of the billed charge or Reasonable Allowance for the service. Please refer to the Definitions found in the back of this document for details.

Reasonable Allowance — The amount determined by Blue Cross and Blue Shield of Nebraska to be payable to noncontracting providers for a covered service.

Copayment — This is a fixed amount you must pay for certain services (if applicable to your health plan).

Coinsurance — This is the percentage you must pay, after the deductible is applied. (Your coinsurance payment is generally lower if you receive services from a Preferred Provider.)

Deductible — There is a calendar year deductible applicable to each covered person before benefits begin. For a family, the maximum deductible amount is limited to twice the individual deductible amount per calendar year. After the deductible is met, benefits for covered services for the rest of that calendar year will not be subject to any further deductible.

The amounts applied to the deductible for covered services by either Preferred Providers or non-Preferred Providers will be credited to both deductibles. Copayments and charges for noncovered services or amounts in excess of the allowable charge do not count toward your deductible.

Coinsurance Limit — The coinsurance limit is the total amount of coinsurance each covered person must pay in a calendar year, except as noted below. When the amount of your eligible coinsurance payments equals the dollar amount specified on your Schedule of Benefits, the coinsurance percentage no longer applies for the rest of the calendar year. For a family, the maximum coinsurance amount is limited to three times the individual maximum coinsurance amount per calendar year. After that, benefits for the rest of that calendar year will not be subject to any further coinsurance amounts.

Certain kinds of expenses do not count toward your coinsurance liability limit. For example:

- Charges in excess of the allowable charge.
- Charges for services that are not covered by this group plan.
- The coinsurance for treatment of mental illness, drug abuse and alcoholism under any part of this group plan (except for Serious Mental Illnesses as specified).
- The copay for treatment of mental illness or substance abuse (if applicable).
- The co-payment for physician office services or other specified services (if applicable).
- The calendar year deductible.
- The reduction amount as a result of a failure to comply with inpatient notification and certification provisions.
- The co-payment for a prescription drug charge processed under the Rx Nebraska Prescription Drug Program.

Your deductible, copayment, coinsurance and coinsurance liability limit amounts are chosen by your employer and are shown on your Schedule of Benefits.

Total Benefits — Your Schedule of Benefits shows a specific dollar maximum per insured for benefits under this group plan. Separate maximums applicable to specific benefits under your group health plan will also be indicated on your Schedule of Benefits.

NOTICE

Non-Preferred Providers' charges may be higher than the benefit amount allowed by this group plan. You may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center concerning allowable benefit amounts for specified procedures in Nebraska. Your request must specify the service or procedure, including any service or procedure code(s) or diagnosis-related group, and the provider's estimated charge.

Utilization Review

Benefits are available under the group health plan for **medically necessary** and **scientifically validated** services. Services provided by all health care providers are subject to **utilization review** by Blue Cross and Blue Shield of Nebraska. Services will not automatically be considered medically necessary because they have been ordered or provided by a physician. Blue Cross and Blue Shield of Nebraska will determine whether services provided are medically necessary under the terms of the plan, and benefits available. **Please refer to the definitions in the back of this book for a description of these terms.**

Fraud or Misrepresentation

A covered person's coverage may be canceled for fraud or misrepresentation about a claim or eligibility for this coverage.

If a misrepresentation is made in connection with your enrollment and is discovered within two years of the enrollment, coverage may be rescinded and you and your dependents will not be eligible for benefits. The amount of premiums paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, we may recover the difference.

Medical Records

In consideration for the processing of claims, Blue Cross and Blue Shield of Nebraska will be entitled to receive such facts, records, and reports about the examination or treatment of Covered Persons as may be needed to process claims or to determine the appropriateness of benefit payment. The Covered Person agrees that in consideration for benefits available, he or she consents to the release of such information to Blue Cross and Blue Shield of Nebraska.

Payments Made in Error

Payments made in error or overpayments may be recovered by Blue Cross and Blue Shield of Nebraska, as provided by law. Payment for a specific service or erroneous payment shall not make Blue Cross and Blue Shield of Nebraska or the group health plan liable for further payment of the same condition.

Inpatient Notification, Certification And Concurrent Review

Notification Requirements

Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospitalizations prior to admission. When you are treated at a BluePreferred hospital notification will be provided by the hospital.

When you are hospitalized in a Non-BluePreferred hospital or in a hospital outside of Nebraska, it is your responsibility to see that Blue Cross and Blue Shield of Nebraska is notified of the admission. Notification may be made by you, your physician, the hospital, or someone acting on your behalf. If the anticipated admission date changes, notification of the change must be made. Make sure you advise the members of your family about these requirements since they apply to you and your covered family members.

If you fail to provide notification of the admission, allowable charges for all covered services associated with that stay may be reduced by 25%. Benefits for all services which are determined to be not medically necessary will be denied.

Emergency admission: Blue Cross and Blue Shield of Nebraska must be notified of an admission for an emergency medical condition within 24 hours of the admission (or the next business day). If notification is not received, the 24-hour period prior to the admission and the 24 hour period after such admission will be reviewed to determine if the patient's condition and treatment would have hindered his or her ability to provide notice.

NOTE: Admission through the emergency room does not necessarily constitute an emergency admission.

Maternity admission: Federal law provides for a length of stay of up to 48 hours following a normal vaginal delivery and 96 hours following a cesarean section unless otherwise agreed to by the patient and her physician. Notification or Certification is not required for an initial maternity admission. However, certification is required if the hospitalization extends beyond these times.

Certification Requirements

All inpatient admissions related to the treatment of mental illness and/or substance abuse; physical rehabilitation; long term acute care and skilled nursing facility care must be precertified for benefit payment. Precertification is required regardless of the PPO/Preferred status of the hospital or facility and whether it is in or out-of the state of Nebraska.

When Blue Cross and Blue Shield of Nebraska receives a request for certification the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by Blue Cross and Blue Shield of Nebraska (or by persons designated by Blue Cross and Blue Shield of Nebraska).

The physician, hospital, covered person or someone acting on the covered person's behalf may request the certification. Blue Cross and Blue Shield of Nebraska will notify such provider, the covered person or someone acting on the covered person's behalf whether or not benefits will be certified for an inpatient admission and the number of days considered medically necessary.

When possible, admission certification by the facility or physician should be arranged prior to the inpatient admission. Claims may be denied if the covered person's condition or the facility does not meet the criteria for the admission.

If certification of an admission by the covered person was possible, and not made, the allowable charge for all related services may be reduced by 25%. In addition, benefits for services determined to be not medically necessary will be denied.

The Concurrent Review Process

Concurrent Review is a review of an ongoing inpatient admission to analyze the medical necessity and appropriateness of your continued inpatient stay.

If additional days are needed beyond the number of days originally certified, benefits for those days must also be certified. The hospital or other facility will be advised to call Blue Cross and Blue Shield of Nebraska to determine if additional days are medically necessary.

If the inpatient care is no longer medically necessary beyond the number of days certified by Blue Cross and Blue Shield of Nebraska, benefits for all services that are determined to be not medically necessary will be denied.

If your physician does not agree with this decision, he or she may submit an appeal to Blue Cross and Blue Shield of Nebraska. Additional information may also be submitted at this time. They will notify both you and your physician of the appeal decision. Please refer to the Appeal Procedures section of your booklet for additional information.

Please remember that notification or certification of an inpatient admission does not guarantee payment. All other group plan provisions apply. For example: deductibles, coinsurance, eligibility, exclusions and waiting periods.

If your benefits are reduced or denied due to failure to notify, precertify or a denial of certification, this reduction becomes an additional amount that must be paid by you. However if the hospital, inpatient facility or physician is a BluePreferred or Participating provider with Blue Cross and Blue Shield of Nebraska, they are liable for their services which are determined by Blue Cross and Blue Shield of Nebraska to be not medically necessary. An exception is made if you have agreed in writing to be responsible for such services or the provider has documented in the medical record that you were notified of the determination. You will remain liable for the reduction in benefits for failure to certify. Any reductions made are not considered when computing your coinsurance liability limit.

AVOID WEEKEND ADMISSIONS

Ask your physician to avoid nonemergency weekend admission as most hospitals do not perform surgical or other nonemergency procedures on weekends. Benefits may be denied if this kind of admission is not medically necessary.

Hospital And Facility Services

Inpatient Hospital Care

If you are hospitalized, benefits are available for the following medically necessary covered services and supplies:

Room and board, including cardiac care or intensive care unit.

> **Note:** If you use more than one room during a 24-hour period, benefits will be provided only for one room, based on the most intensive care provided during that period.

Use of operating, recovery and other appropriate treatment rooms and equipment. Benefits are not available for separate rooms used for procedures that are customarily provided in the patient's room.

Anesthesia.

Respiratory care.

FDA-approved drugs, intravenous solutions, vaccines, biologicals and medicines which are prescribed and administered while hospitalized.

Administration and processing of blood, blood plasma, blood derivatives or fractionates.

Supplies, materials and equipment except "take-home" supplies and convenience items.

Radiology (x-ray) and pathology (lab) and other diagnostic services billed by the hospital.

Radiation and chemotherapy, except that "high dose" chemotherapy is limited to procedures which are specifically listed as covered services in the section of this booklet titled: "Organ and Tissue Transplants."

Physical therapy when provided by a licensed physical therapist or a licensed physical therapist's assistant supervised by and assigned to a physical therapist.

Occupational therapy when provided by a licensed occupational therapist, or licensed occupational therapist's assistant supervised by an occupational therapist.

Speech therapy when provided by a licensed speech-language pathologist or registered communications assistant practicing under the direct supervision of a licensed speech-language pathologist.

Reminder: Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. Failure to provide notification of the admission may result in the allowable charges being reduced by 25%.

Long Term Acute Care

Long Term Acute Care is specialized acute hospital care for medically complex patients who are critically ill, have multisystem complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour seven-day-a week basis.

Benefits must be precertified for all Long Term Acute Care admissions regardless of the facility's Preferred or non-Preferred status. If certification of an admission was possible, and not made, the allowable charge for all related covered services may be reduced by 25%.

Physical Rehabilitation Program

Benefits for inpatient physical rehabilitation services must be precertified by Blue Cross and Blue Shield of Nebraska prior to admission. If certification of an admission was possible and not made, allowable charges for all related covered services may be reduced by 25%. The covered person must be disabled and meet specifications for coverage as determined by Blue Cross and Blue Shield of Nebraska. The inpatient rehabilitation must follow within 90 days of the acute hospitalization for the injury, illness or condition causing the disability. Benefits are not available for Custodial Care.

Physical rehabilitation is defined as the restoration of a person who was disabled as the result of an injury or an acute physical impairment to a level of function that allows a person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Benefits are available for covered hospital and physician services, including:

- recreational therapy,
- social service counseling,
- prosthetic devices and fitting, and
- psychological testing.

For benefits to be available for a physical rehabilitation program, the provider must be accredited for comprehensive inpatient rehabilitation by the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Reminder: All inpatient admissions related to an inpatient physical rehabilitation admission must be precertified for benefit payment by Blue Cross and Blue Shield of Nebraska prior to admission. Precertification may take place at any time prior to admission, or within 24 hours after admission.

Skilled Nursing Facility

Benefits are available for up to day limit stated in the Summary of Benefit Maximums for medically necessary skilled nursing care services provided in a semi-private room of a skilled nursing facility. Benefits for all skilled nursing facility admissions must be precertified by Blue Cross and Blue Shield of Nebraska. If certification was possible and not made, the allowable charge may be reduced by 25%.

The covered person must be confined in a free-standing facility licensed by the state as a Nursing Facility (NF) or licensed by the state and/or certified by Medicare as a Skilled Nursing Facility (SNF) or, part of a hospital with designated beds licensed by state law and/or certified by Medicare as Skilled Nursing or Swing Beds. The facility or such part of the facility must provide medically necessary room, board, and 24-hour-a-day skilled nursing care, as well as other related services for the care and rehabilitation of injured, disabled or sick persons.

The skilled nursing facility confinement must be ordered by a physician, be medically necessary and the covered person must be receiving skilled nursing care.

A skilled nursing facility does not include:

- a place that is primarily used for rest, care and treatment of mental illness and/or substance abuse,
- a place for custodial care, or
- a place for educational or non-medical personal services.

Skilled nursing facility care does not include:

- supportive services of a stabilized condition;
- care which can be learned and given by unlicensed or uncertified medical personnel;
- routine health care services;
- general maintenance or supervision of routine daily activities, or
- routine administration of oral or non-prescription drugs.

Inpatient Mental Illness and Substance Abuse

Benefits will be provided for medically necessary, scientifically validated covered services provided for the treatment of mental illness and/or substance abuse as described in the part of this book titled "Mental Illness And Substance Abuse".

All inpatient admissions to any hospital or treatment center for treatment of Mental Illness and/or Substance Abuse must be precertified regardless of whether care is received at a BluePreferred, Preferred or non-Preferred facility in Nebraska or in another state.

When You Use Outpatient Facilities

If you are treated in a hospital outpatient department, ambulatory surgical facility, urgent care facility or other outpatient facility, benefits will be provided for medically necessary services. Benefits will also be provided for an observation room for a period of 24 hours.

Your health plan option may specify a copayment for an emergency room or urgent care facility charge. Please refer to your Schedule of Benefits.

EMERGENCY ROOMS ARE EXPENSIVE

Hospital emergency rooms are very expensive because they are specifically staffed and equipped to handle accidents, injuries and other emergencies. Using them for Preventive care (or as a substitute for the family physician) can cost you time and money.

Outpatient Cardiac Or Pulmonary Rehabilitation

Benefits will be provided for medically necessary outpatient cardiac or pulmonary rehabilitation services. Benefits must be preauthorized by Blue Cross and Blue Shield of Nebraska.

Benefits are available for covered outpatient hospital and physician services, including:

- initial rehabilitation evaluation,
- exercise sessions, and
- concurrent monitoring during the exercise session for high risk patients.

The cardiac or pulmonary rehabilitation program must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or as otherwise approved by Blue Cross and Blue Shield of Nebraska.

Cardiac or pulmonary rehabilitation is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue

perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

Cardiac Rehabilitation — Benefits will be provided for services at any therapeutic level, limited to 18 sessions, for the following diagnoses occurring during the preceding four months:

- an acute myocardial infarction,
- coronary artery angioplasty, with or without stent placement, or other scientifically validated procedure to clear blocked vessels,
- heart or coronary artery surgery,
- heart transplant,
- heart-lung transplant, or
- cardiac rehabilitation for treatment of congestive heart failure and stable angina initially and after significant changes in clinical status as determined by Blue Cross and Blue Shield of Nebraska.

Pulmonary Rehabilitation — Benefits will be provided prior to and following:

- lung transplant,
- heart-lung transplant,
- lung volume reduction surgery, and
- for severe chronic lung disease patients as

reviewed and determined by Blue Cross and Blue Shield of Nebraska.

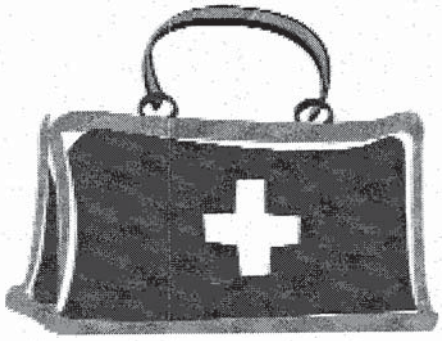
Pulmonary rehabilitation services will be limited to the following:

- Chronic lung disease patients are limited to 18 sessions (including follow-up home sessions) initially and after significant changes in clinical status. However, no more than 18 sessions will be covered in a single calendar year.
- Lung transplant, heart-lung transplant and lung volume reduction surgery patients are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery.
- Pulmonary rehabilitation services will be covered only when under continuing supervision of a physician and in a hospital environment.

Preauthorization Request Procedure: Benefits must be preauthorized by Blue Cross and Blue Shield of Nebraska for a cardiac or pulmonary rehabilitation program, prior to starting the program. A written request for preauthorization should be directed to Blue Cross and Blue Shield of Nebraska, Attention: Medical Support Department, P.O. Box 3248, Omaha, Nebraska 68180-0001.

Blue Cross and Blue Shield of Nebraska will notify both the covered person and the provider in writing about the approval or disapproval of coverage. If benefits are not preauthorized, claims for such benefits may be denied if the covered person's condition or the program does not meet established criteria.

Physician's Services



Benefits are available for covered services provided by a physician or oral surgeon, a certified nurse midwife, a certified nurse practitioner or certified physician's assistant, within the practitioner's scope of practice, when supervised and billed by a physician.

Covered services include:

Surgical Expenses. The amount payable for a covered inpatient or major outpatient surgical procedure includes normal care before and after surgery (preoperative and postoperative care).

If two or more Physicians are involved, the benefits payable for the procedure(s) shall not exceed the Allowable Charge.

When multiple or bilateral surgical procedures are performed which add significant time or complexity at the same operative session, benefits for the primary procedure will be paid as determined by Blue Cross and Blue Shield of Nebraska. For any secondary procedure or additional procedure, the allowable charge will be 50% of the allowable charge had the procedure been primary. When surgery is performed in two or more steps, benefit payment will be made as a single procedure.

Surgical Assistance. Benefits of up to 20% of the amount payable for surgery will be available for surgical assistance by a physician or other approved provider, within his or her scope of practice, who actively assists the operating physician for certain procedures. Benefits for surgical assistance are available for covered procedures specified by Blue Cross and Blue Shield of Nebraska. Please contact their Customer Service Center for specific information.

OUTPATIENT SURGERY

Many surgical procedures can be performed as an outpatient. This can save you time and trouble by allowing you to return home on the same day. Ask your physician about outpatient surgery.

Anesthesia Services by a physician or certified registered nurse anesthetist. The amount payable for anesthesia services will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration of the anesthesia. Payment will not be made for supervision of the administration of anesthesia. Benefits will not be provided for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks related to pregnancy or general anesthesia for covered oral surgery and dentistry procedures under this contract).

Benefits are also available for an oral surgeon or dentist with a permit issued by the state, to administer general anesthesia.

Inpatient Hospital Visits for a medical condition for which surgical care is not required.

Concurrent Inpatient Hospital Visits by two or more physicians on the same day if their services are:

- for unrelated nonsurgical medical diagnoses which require the services and skills of two or more physicians with unrelated specialties, or
- necessary because of medical complications requiring additional skills not possessed by the attending surgeon or assistant surgeon.

Consultations by providers with different specialties or sub-specialties when requested by the physician in charge of your care and when your condition requires special care or knowledge not possessed by your attending or other consulting physician(s). The consultation must include a physical examination and written report in the covered person's hospital chart or conveyed to the referring physician.

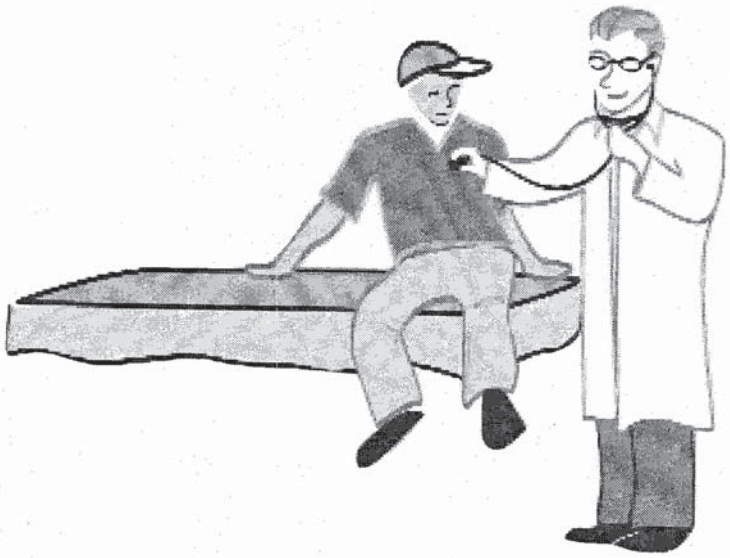
Intensive Medical Services. Unusual, repeated and prolonged attendance at the covered patient's bedside when required by the illness, injury or pregnancy.

Radiation therapy, nuclear medicine chemotherapy and injectables, except as excluded (or not specifically listed as covered) under the section titled "Organ and Tissue Transplants."

Tissue exams related to covered surgical procedures.

PREADMISSION TESTING SAVES TIME AND TROUBLE

Preadmission tests are x-ray and lab tests which are performed in a hospital's outpatient department before you are admitted for surgery. This can save you extra time in the hospital.



Physician visits for nonroutine care in the patient's home, the outpatient department of a hospital or an ambulatory surgical facility.

FDA-approved drugs, intravenous solutions, vaccines, biologicals, and medicines which are prescribed and administered to the covered person in the physician's office.

Physician office services are subject to either a copayment amount or to the deductible and coinsurance, as indicated on your Schedule of Benefits. For purposes of this benefit, "physician" includes an internist, obstetrician/gynecologist, pediatrician, family or general practitioner. Covered services include:

- office visits;
- consultations;
- preventive exams and periodic check-ups:*
- well-baby care:*
- radiology (x-ray) and pathology (lab);
- routine immunizations;
- pap smears (routine* and medical);
- vision exams and hearing exams* (excluding exams by an optometrist);
- injections of allergy extracts and immunizations, including pediatric immunizations; and
- supplies used during the office visit.

** If Preventive Care Services are listed separate from Physician Office Services on your Schedule of Benefits, these services and other services identified in the paragraph titled Preventive Care are subject to the Preventive Care copayment, deductible and coinsurance amounts which may be different than the Physician Office Services amount.*

Specialist office services. Covered services provided in the office of a physician specialist, excluding an internist, obstetrician/gynecologist, pediatrician, family or general practitioner, are subject to the copayment or deductible and coinsurance amount specified on your Schedule of Benefits. Specialist office services include vision exams by an optometrist.

NOTE: The following covered services are <u>not</u> payable subject to the physician office services copay or the specialist office service copay: services received in a hospital or other inpatient or outpatient facility; surgical procedures; anesthesia; assistant surgeon; physical or speech therapy; chiropractic manipulations; chemotherapy; nuclear medicine; injectables; sleep studies; pregnancy or maternity services; Home Medical Equipment; prosthetics; preventive immunizations; office visits, services or supplies related to Mental Illness or Substance Abuse. Benefits for such covered services will be subject to the applicable deductible and coinsurance.

Preventive Care

The following information only pertains to you if your Schedule of Benefits lists Preventive Care Services separate from Physician Office Services.

Benefits are available as specified on your Schedule of Benefits for the following covered preventive care services:

- periodic physical exams;
- periodic well-child exams;
- routine office visits;
- routine cardiac stress tests;
- routine mammograms;
- routine pap smears;
- routine PSA tests;
- routine colonoscopies;
- routine immunizations;
- routine hearing and vision exams, excluding refractions; and
- charges for radiology and laboratory testing related to covered preventive care services.

Pregnancy And Maternity Care

Benefits for pregnancy and maternity care are not available on all group health plans. If your plan does not include maternity coverage, disregard the following information and refer to the section titled "Complications Of Pregnancy."

Benefits are available for hospital, surgical and medical care for pregnancy. Benefits for prenatal and postnatal care (excluding the initial visit) are included in the payment for delivery. Benefits include care for complications of pregnancy or interruptions of pregnancy. These maternity benefits are available to you or your covered spouse or eligible dependent daughter.

Benefits are also available for obstetrical care provided by a certified nurse midwife when such obstetrical services are within their scope of practice and such services are supervised and billed for by a physician.

Benefits may not, under Federal law, be restricted for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier. Also, under federal law, a plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the patient than any earlier portion of the stay. In addition, a plan may not require the provider to obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

NOTE: Hospital stays that extend beyond 48 hours (or 96 hours) should be certified.

For verification of maternity benefits, please check your Schedule of Benefits, or you may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center for information.

Complications Of Pregnancy

If your group health plan does not include maternity benefits, you still have benefits available for complications of pregnancy. A complication of pregnancy is an illness or condition occurring prior to the end of the pregnancy which is distinct from the pregnancy, but are caused or adversely affected by it.

The need for a cesarean section is not considered a complication of pregnancy.

Postpartum depression, psychosis or any other mental illness are not considered complications of pregnancy under this part. Limited benefits for this type of condition are provided under your mental illness benefits.

If your plan does not include coverage for pregnancy and maternity care, benefits are not available for services for, or related to pregnancy, maternity care or pregnancy-related conditions including, but not limited to gestational diabetes, gestational hypertension, iron deficiency anemia or other conditions related to pregnancy.

Newborn Care

Benefits will be available at birth for covered services for an eligible newborn infant. Covered services

include: room and board, screening tests including the newborn or infant hearing exam, physician's services for a newborn while hospitalized including circumcision, newborn screening services for an infant born at home, and medically necessary definitive medical or surgical treatment.

If you have a Single or Subscriber-Spouse Membership in effect, coverage shall begin at birth for a period of 31 days. To continue coverage for the newborn child, you must request a change to a Family or Subscriber-Children Membership and enroll the child within 31 days of the birth and pay the additional premium.